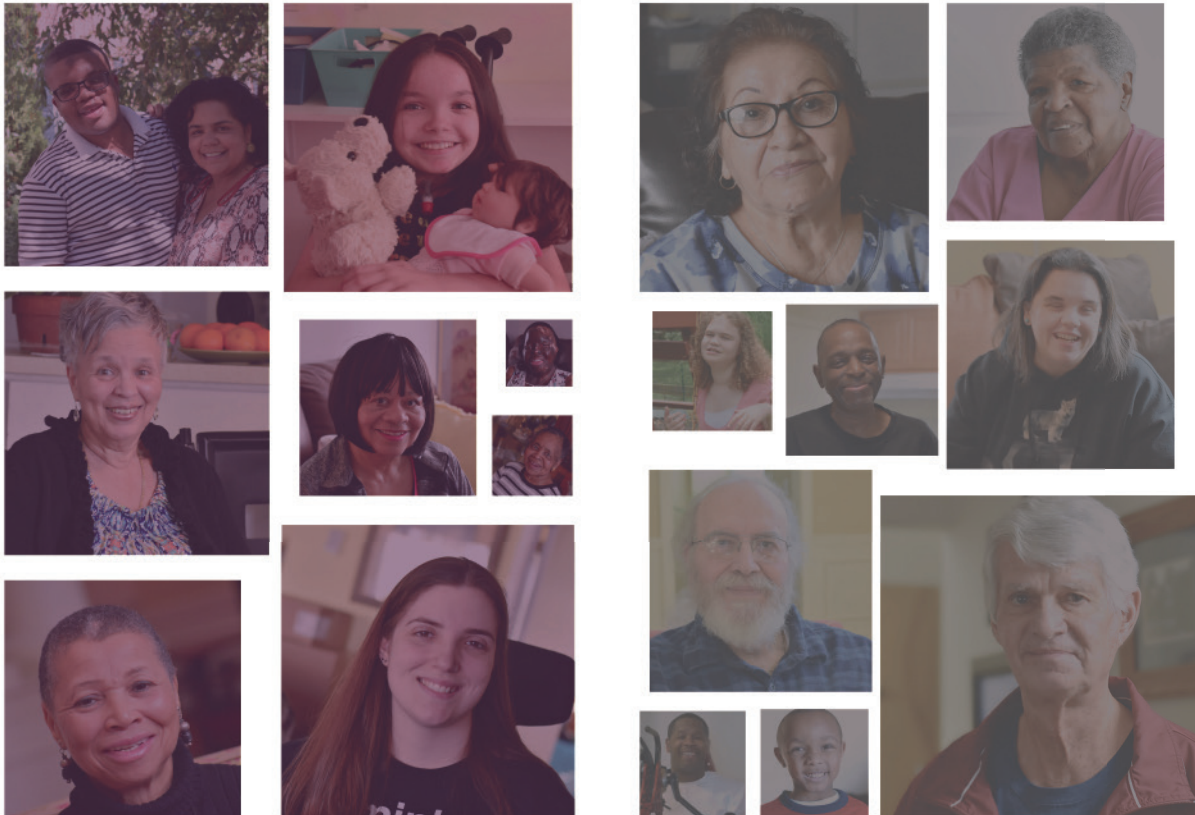




THE COORDINATING CENTER
INSPIRED SOLUTIONS



2019

ANNUAL REPORT

VISION

People of all ages and abilities have equitable access to achieve optimal quality health, affordable housing and meaningful quality of life.

MISSION

The mission of The Coordinating Center is to partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health, and meaningful community life.

VALUES

Excellence: We challenge ourselves to do great work.

Integrity and Impact: We uphold ethical standards and we make a difference.

Collaboration: We are better together.

Equity and Inclusion: We value diversity in many forms.

Learning: We believe continual learning is essential.



A Message From Our CEO

It has been both a privilege and an absolute pleasure having transitioned to President/CEO of The Coordinating Center (“The Center”) this year. I have seen firsthand the incredible commitment of our coworkers and Board of Directors to The Center’s mission, vision and values and the people we are privileged to serve. The Center has an outstanding reputation in Maryland for providing top-notch case management services for people with disabilities and complex medical needs and will continue to be the premier nonprofit dedicated to helping people of all ages and abilities have equitable access to achieve optimal quality health, affordable housing and meaningful community life. In 2019, our dedicated team of over 300 coworkers, including licensed nurses and social workers, community health coaches, service coordinators, housing coordinators and life care planners and operations experts supported more than 10,000 children and adults with disabilities and complex needs across the State of Maryland. Since joining The Center, together we have:

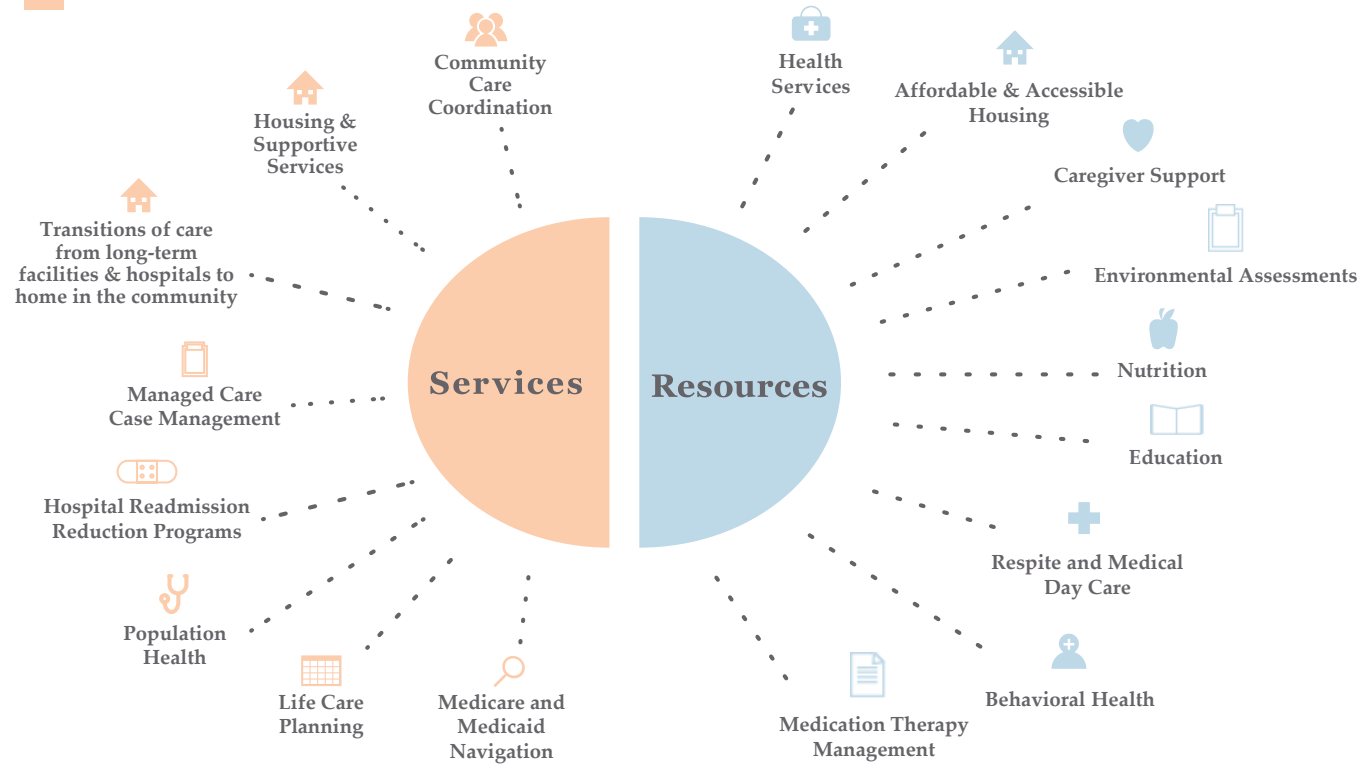


- Expanded supports planning and housing locator services statewide to more than 500 older adults and non-elderly disabled, helping them live and remain in their community.
- Expanded The Center’s capacity to provide service coordination and support services for formerly homeless adults enrolled in Montgomery County’s Housing Initiative Program (HIP).
- Demonstrated significant cost savings for two Regional Partnerships with local area hospitals: the Bay Area Transformation Project in Anne Arundel County and the Nexus Montgomery Regional Partnership in Montgomery County and parts of Prince George’s County.
- Demonstrated significant return on investment for a local Managed Care Organization by providing case management services for adults with complex needs and chronic conditions, and expanded case management services to include pediatrics in July 2019.
- Established VIPhysicians&Kids, a new medical home model for children and youth with special needs funded by the Maryland Department of Health’s Office for People with Special Health Care Needs.
- Awarded a competitive rebid for The Center’s largest contract, the Rare and Expensive Case Management Program (REM), providing for case management services for individuals receiving Maryland Medical Assistance with a qualifying diagnosis that is rare and expensive to treat.
- Received approval from the Maryland Developmental Disabilities Administration to become a provider of Coordination of Community Services for people with intellectual and developmental disabilities, a program that will launch in 2020.

I look forward to working with The Center’s Board of Directors led by Thomas H. Hall, Board Chair and our Coworkers on implementing our three strategic planning objectives: coworker retention, sustainability and growth, measuring impact and Coworker retention. The Center is committed to expanding services for people with intellectual and developmental disabilities, measuring the impact of our programs, and investing in our Coworkers. Thank you to all of our partners, supporters, and funders for another wonderful year! Sincerely,

Teresa Titus-Howard, PhD, MHA, MSW

How We Help



Family Resource Fund

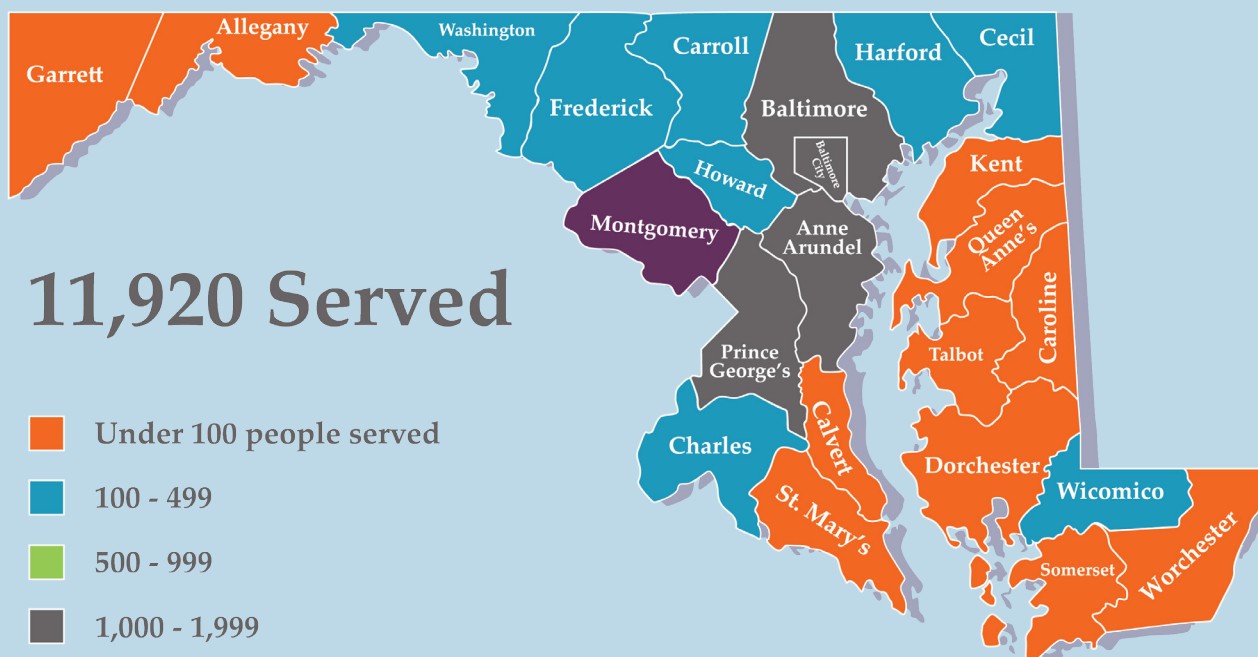
The Family Resource Fund, initially called the “Crib Fund,” was started 34 years ago by The Center’s Coworkers to help families and their little ones with complex medical needs transition from hospital-to-home when no other funding was available. Today, this fund assists children and adults with disabilities, people experiencing homelessness and housing insecurity, and people with chronic conditions and frequent hospital encounters, many of whom are impacted by social determinants of health, such as food insecurity and unemployment. When clients at The Center could benefit from a helping hand, The Family Resource Fund is used as a last resort to support critical need requests, items an individual or family cannot live without such as housing (i.e., rapid rehousing and critical home modifications), medical equipment, medical supplies, hearing aids, eye glasses, dentures/dental work, and other items not covered by Medicaid, or other insurance providers. Additionally, the fund assists with quality of life requests such as assistive technology devices, adaptive equipment (i.e., adaptive travel strollers, and car seats), respite and summer camp.

194
People Served
FY 2019

\$49,588
Distributed

20%
Supports Critical
Housing Needs

Where We Help



11,920 Served

MEET ALIAN

At an early age Alian fell in love with the game of soccer, he continued to play the sport until one day he suddenly fell ill. Alian, who was 16 at the time was rushed to the hospital where he was diagnosed with kidney failure. After receiving a kidney transplant Alain developed diabetes and was referred to The Coordinating Center by his primary care physician for support with managing his new diagnosis. Alian’s new diagnosis came with some harsh realities, including the need for him to stop playing competitive soccer.

Being connected with The Coordinating Center and working with his coordinator has helped Alian in more ways than he could ever imagine. Alian’s coordinator helped him navigate insurance mishaps, access medications, arrange transportation and connected him with a therapist to help him cope with his new lifestyle and sudden changes. When Alian could not afford the medical supplies and equipment he needed to manage his diabetes, his coordinator applied for funding from The Center’s Family Resource Fund to cover the out of pocket expenses.

Despite all of these new realities, Alian was able to find a new passion, which he discovered when he entered an acting competition and won first place. The competition helped Alian discover his hidden talent and gave him something new to look forward to. “It wasn’t until I was in the room with all these producers, agents, and directors that I realized that acting is something I should really pursue.”

Alian is now able to pursue his acting passion without constantly worrying about the stress of managing his health thanks to The Coordinating Center and the Family Resource Fund.



Care Management Services

Care Management Services at The Coordinating Center help people living with complex medical needs and disabilities live independently. The vast majority of people supported have developmental disabilities such as Cerebral Palsy or Autism Spectrum Disorder, genetic disorders (i.e., Cleft Palate), physical disabilities (i.e., quadriplegia), and/or chronic diseases (i.e., End Stage Renal Disease, Parkinson’s or Muscular Dystrophy). Often, it is difficult for them to live independently without connection to the proper resources, consistent medical follow-up and community supports. Our Clinical Care Coordinators (i.e., licensed nurses and social workers) are highly skilled in helping children and adults with disabilities, and their families’ access services and resources that allow them to not only survive, but thrive in their homes and in their community. As the sole source provider of care management services for the Maryland Model Waiver and Rare and Expensive Case Management (REM) program, our Care Management Services Team coordinates community services and:

- Provides people with specialized health care needs access to high quality, medically appropriate health care services in a cost effective setting outside of a managed care organization;
- Helps children and adults with disabilities avoid costly long-term hospitalization;
- Helps coordinate and participate in medical appointments;
- Attends Individual Education Plan (IEP) meetings;
- Anticipates, prepares and plans for all transitions including early intervention to school, hospital to home, pediatric care to adult health care; and,
- Educates children, youth and families on self-management skills.

Our Impact

4,622
People Served
FY 2018

4,492
People Served
FY 2019



MEET HAILEY

When Hailey was two years old, she took a fall in the bath tub. This incident led doctors to discover Hailey had a rare condition called Klippel-Feil syndrome, that would leave her in a wheelchair. Her doctors painted a grim picture for Hailey’s future, expecting her not to speak or reach other developmental milestones. Nine years later, Hailey proved her doctors wrong. Hailey is not defined by her disability, but rather her spirit. She is as active as any other 11-year-old, and when Hailey is not busy with cheerleading, singing and/or dancing, you can find her playing with her dog or working on her latest arts and crafts project. “You always have to try, if you can’t do it that’s okay, but you have to try” this is the mantra Hailey’s grandmother, Dawn teaches Hailey to live by. Hailey was selected by Mt. Washington Pediatric Hospital as a student ambassador to represent children with disabilities at the Capitol in Washington, DC. During her trip Hailey spoke with Senator Chris Van Hollen and shared with him how important it is to maintain public funding for Medicaid programs, as it is the only way she can afford the care she needs.

Medical Legal Services Division

The Medical Legal Services Division continues to provide comprehensive Life Care Planning Services to advocates in the legal community. Over the past two years, the division has expanded services to individuals who, following litigation, are the recipients of special needs trusts and similar funding supports. Utilizing their expertise in the delivery of community based resources for care, the division’s Life Care Planners and Care Coordinators have forged partnerships with numerous clients and their representatives to support full community inclusion and access for both children and adults with special health care needs and disabilities. Working with specialists in home accessibility, home care, specialty equipment, medicine and rehabilitation, the Medical Legal Care Coordinators have worked to provide services that are both inclusive and cost efficient while striving to optimize the functional outcomes and safety of the individuals in the community.

Year of Service Since 2018



851
Hours of
Service to date

27
Organizations
to date

285
Volunteers
to date

Home and Community Support Services

Home and Community Support Services (HCSS) at The Coordinating Center provide children and adults enrolled in Community First Programs and/or the Autism Waiver access to in-home and in-community supports and services that enable them to thrive in the community. Support Planners are skilled at helping people navigate complex systems (i.e., medical, social, and educational), coordinate care, and move people from institutions, such as nursing facilities and hospitals, to homes in the community. Using a person-centered planning approach Support Planners work with each individual to customize a plan of care that is centered on achieving personal goals and aspirations.

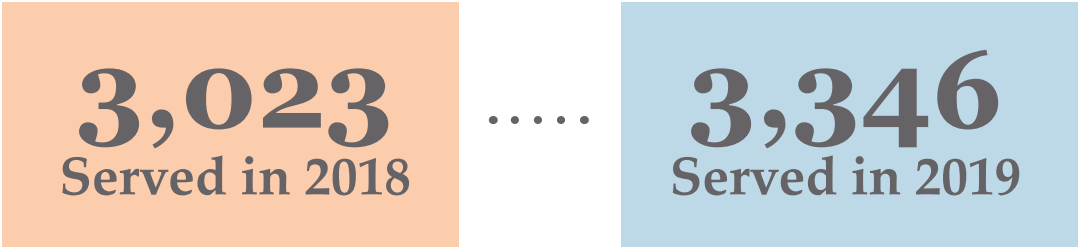
Our Impact



Community First Programs (CFP)

Support Planners coordinate care for Medicaid beneficiaries statewide who are enrolled in a home and community-based service program or waiver: Home and Community-Based Options Waiver, Community First Choice Program, Community Personal Assistance Services and Increased Community Services. Participants and their families gain access to:

- Personal Assistance Services
 - Nurse Monitoring
 - Personal Emergency Back-up Systems
 - Transition Services
 - Consumer Training
 - Home Delivered Meals
 - Assistive Technology
 - Accessibility Adaptations
- Environmental Assessments
 - Medical Day Care
 - Nutritionist/Dietician
 - Family Training
 - Behavioral Consultation
 - Assisted Living
 - Senior Center Plus
 - Other Services as needed



Autism Waiver Services

Support Planners assist students living in Dorchester, Harford, Howard and Worcester County who have an Autism Spectrum Diagnosis and an institutional level of care, receive the services and supports they need to live safely in their home and community. The Autism Waiver offers services that promote increased independence with daily life skills, as well as support for their parent/caregiver. Without these services, these students are at risk for out of home placement.

- Respite Care
- Environmental Accessibility Adaptations
- Family Training Intensive Individual Support Services
- Intensive Therapeutic Integration Services (after school program)
- Residential Habilitation (regular/intensive)
- Adult Life Planning

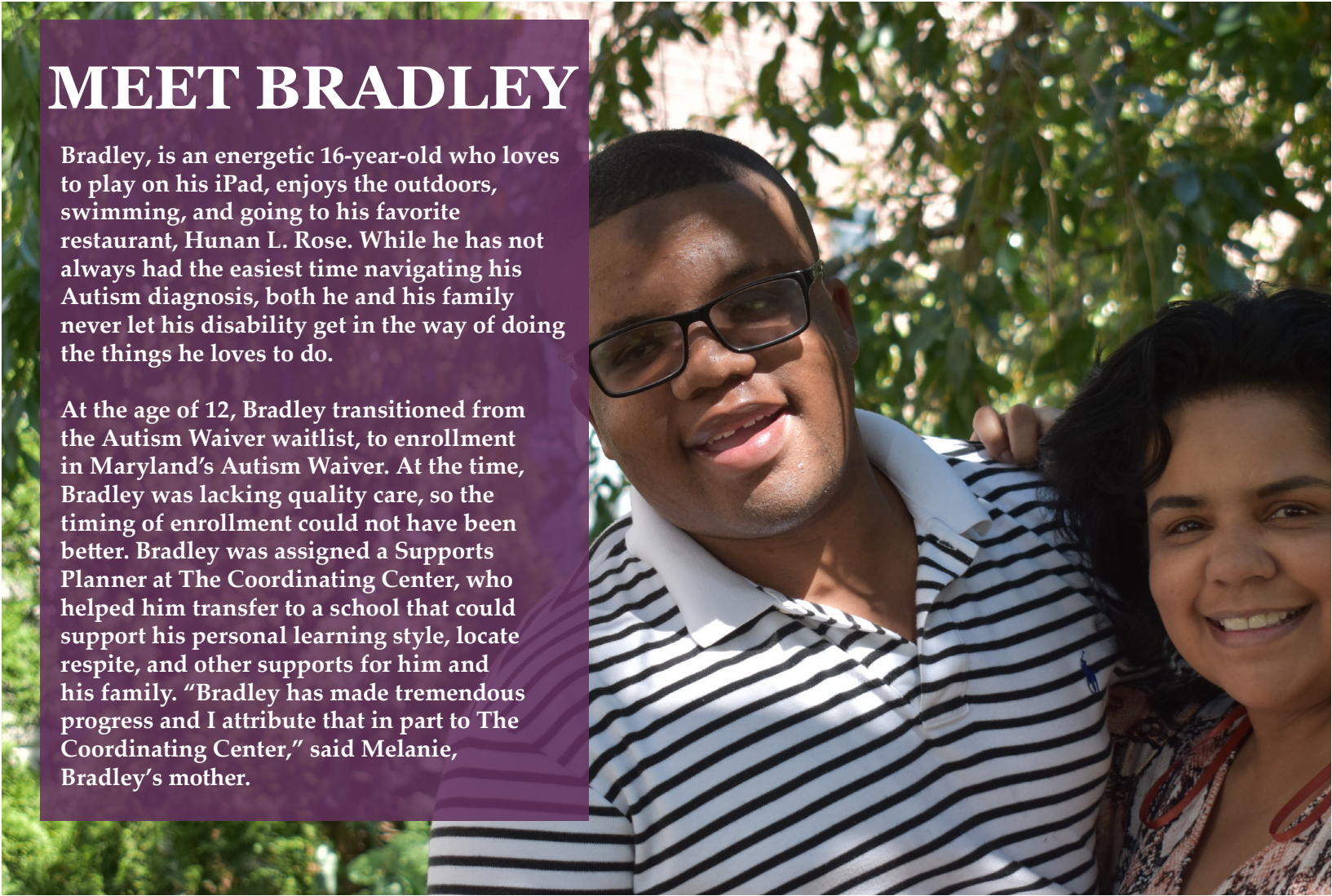
Our Impact



MEET BRADLEY

Bradley, is an energetic 16-year-old who loves to play on his iPad, enjoys the outdoors, swimming, and going to his favorite restaurant, Hunan L. Rose. While he has not always had the easiest time navigating his Autism diagnosis, both he and his family never let his disability get in the way of doing the things he loves to do.

At the age of 12, Bradley transitioned from the Autism Waiver waitlist, to enrollment in Maryland’s Autism Waiver. At the time, Bradley was lacking quality care, so the timing of enrollment could not have been better. Bradley was assigned a Supports Planner at The Coordinating Center, who helped him transfer to a school that could support his personal learning style, locate respite, and other supports for him and his family. “Bradley has made tremendous progress and I attribute that in part to The Coordinating Center,” said Melanie, Bradley’s mother.

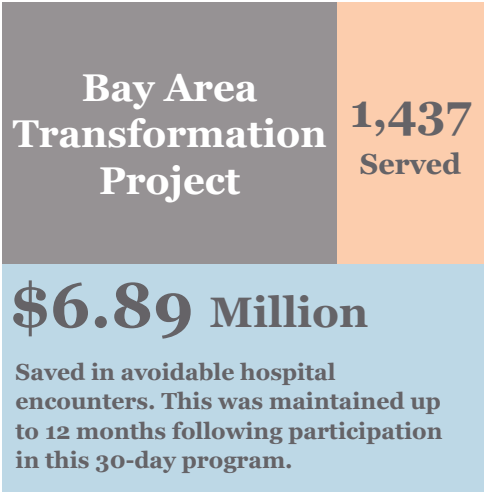
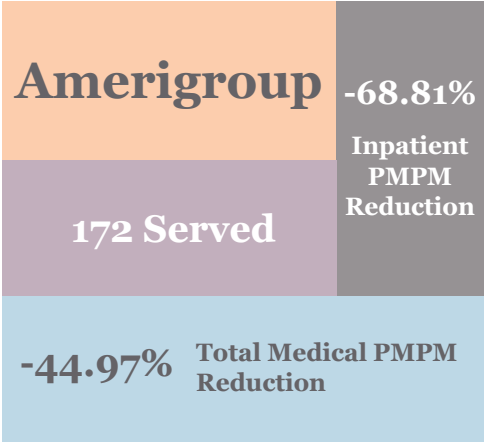
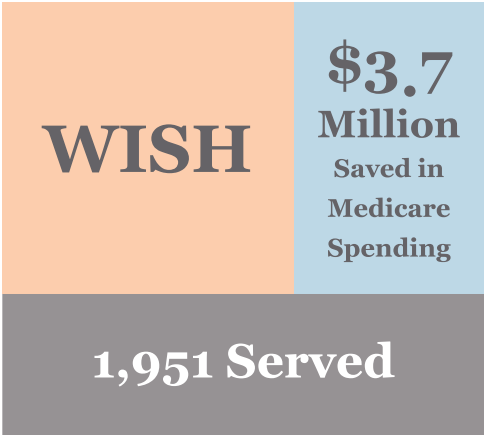




Community Health Services

The Coordinating Center partners with hospitals, physician practices and managed care organizations to deliver customized care coordination programs that focus on improving population health. Our team has significant experience moving individuals from one healthcare setting to another, assisting with planning, logistical coordination, advocacy, identification of person goals and motivators, and education. Much of our work is focused on the goal of reducing unnecessary health service utilization (emergency room, observation and inpatient), and addressing the social determinants of health (SDOH). SDOH are the complex circumstances in which individuals are born and live that impact their health. They include intangible factors such as political, socioeconomic, and cultural constructs, as well as place-based conditions including accessible healthcare and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthful food.

- In 2019, The Center demonstrated significant cost savings for two Regional Partnerships with local area hospitals: the **Bay Area Transformation Project** in Anne Arundel County and the **Nexus Montgomery Regional Partnership** in Montgomery and parts of Prince George’s County. The Center provided coaching and care coordination services for the Wellness & Independence for Seniors at Home (WISH) program, funded by the Nexus Montgomery. WISH is unique because it aims to reduce avoidable hospital use by connecting older adults to the services they need before their health declines.
- The Center’s complex case management services for Managed Care Organizations (MCO) has consistently outperformed other case management programs both within and contracted by the MCO.
- The Center is certified by the Utilization Review Accreditation Commission (URAC) in case management accreditation, and has successfully participated in the National Committee for Quality Assurance (NCQA) Health Plan certification process three times over the past fourteen years, meeting all requirements and standards.
- VIPhysicians&Kids, The Center's new medical home for children and youth with special health care needs launched in 2019 with support from the Maryland Department of Health's Office for Genetics and People with Special Health Care Needs.



MEET JEANNE

Jeanne is a loving mother and grandmother, who was born and raised in Alabama and spent the last 18 years living in Southern California to be near her daughter and grandchildren. Yet, even after 18 years, Southern California never felt like home for Jeanne.

At the age of 95, Jeanne decided to make a bold move. Jeanne relocated to Maryland to continue to live close to her daughter, who had recently relocated to Maryland for a new job.

At first the move was difficult, however with the support of her family and the WISH program life in Maryland started to feel like home for Jeanne. Jeanne’s WISH Health Coach, helped her receive the tools and resources she needed to manage her diabetes and diet, as well as keep her feeling safe and secure in her new home. Jeanne’s Health Coach connected her with a local dietician, affordable fresh food, and an iPad, which she uses to stay connected to her family, friends and needed resources.

“Many people have a misconception that WISH is a medical treatment program and even though it’s not, it’s just as valuable. As I worked through this planning stage, I discovered that many doors started opening with ideas and solutions building at an exciting pace.”

Wellness and Independence for Seniors at Home (WISH) helps older adults remain healthy and independent by providing a Health Coach who can help them develop a health plan and connect to resources in the community. WISH aims to reduce avoidable hospital use by connecting older adults to the services they need before their health declines.



Housing and Support Services

The Coordinating Center works statewide, helping individuals locate, secure, and maintain safe, affordable and accessible housing opportunities in the community of their choice. The Center’s highly skilled Housing Coordinators assist individuals living in long-term nursing facilities to support their transition back to the community, and help those living in the community remain at home and avoid unnecessary transitions into a long-term care facility. Coordinators help individuals understand and identify different housing opportunities, assist with obtaining the necessary documentation and provide resources to successfully maintain good tenancy. In addition, The Center has expertise in working with homeless individuals who have chronic health conditions. Through the Housing Initiative Program (HIP) in Montgomery County, The Center provides care coordination assisting individuals to access all appropriate medical, health and social services so they may successfully integrate into their community.



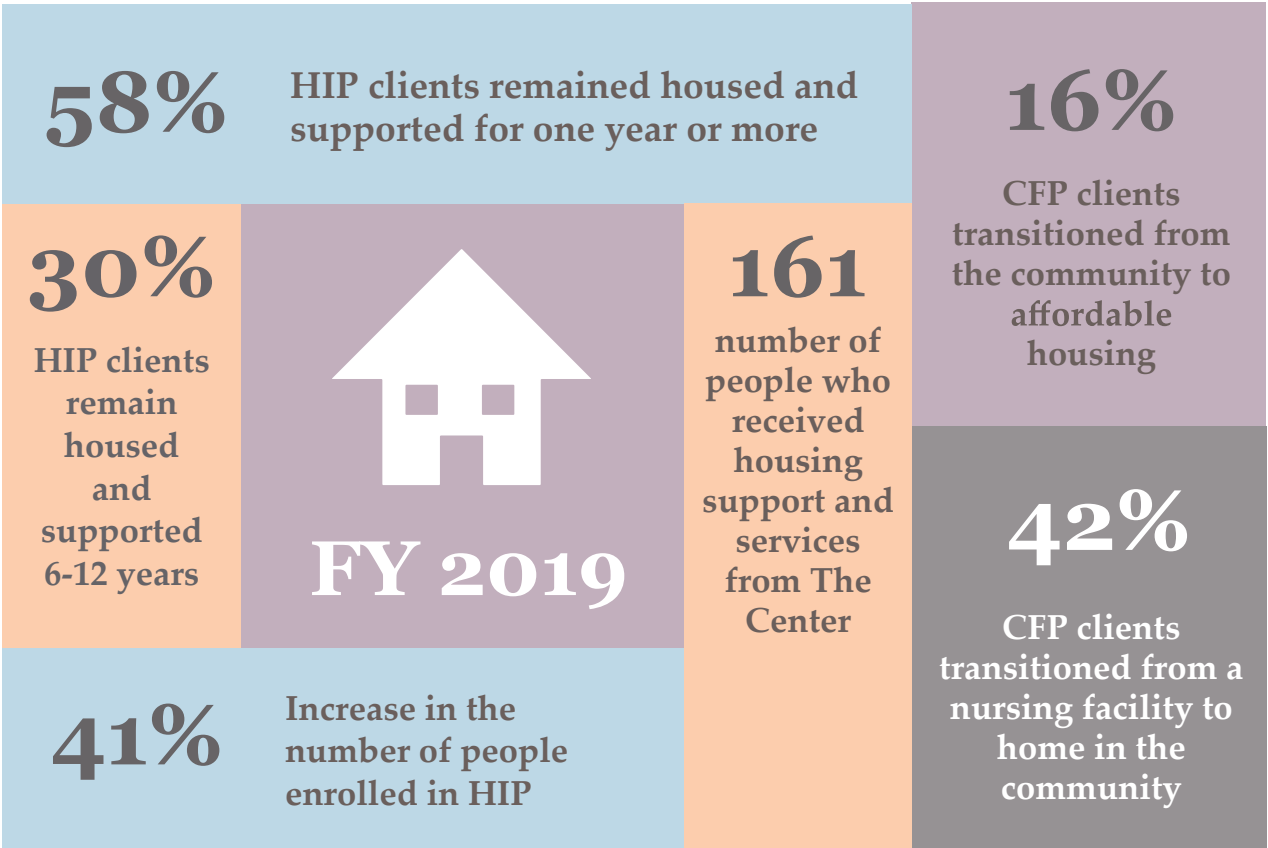
MEET BEVERLY

After working for a company for several years, Beverly received the unfortunate news that she was being laid off. This event created a snowball effect in Beverly’s life, ultimately leading to losing her home. Now homeless, Beverly turned to a shelter for support. It was there where she was first introduced to Montgomery County’s Housing Initiative Program (HIP) and The Coordinating Center.

Beverly was apprehensive at first and it took some convincing from a staff member at the homeless shelter and encouragement from her new shelter friends, who had applied for similar housing support services, but ultimately, she moved forward with applying. After only a few weeks Beverly was assigned by the County to a housing coordinator at The Center. The immediate goal was to locate affordable and accessible housing that would meet the requirements of her housing voucher.

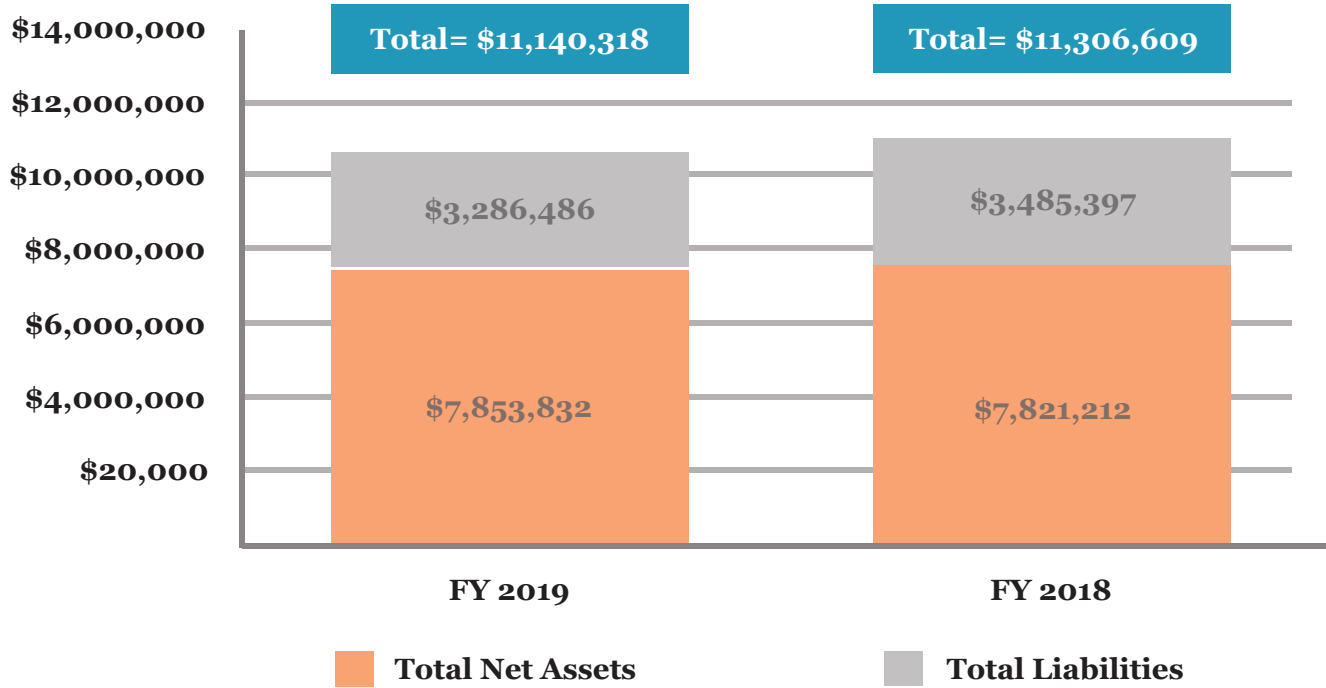
Beverly shared that one of the biggest challenges her coordinator faced was finding a place that not only met the guidelines of the program, but doing so in such a short period of time. “I didn’t think we’d be able to do it, but with only five (5) days left on my voucher, my coordinator called me and told me she found me a new home.”

With the help of her housing coordinator at The Center and the HIP Program, Beverly moved into her own apartment and now has a space to call home. On the weekends and holidays, Beverly hosts gatherings and dinners for her friends she made at the shelter. “I tell everyone about this program and how good my Coordinator has been to me.”



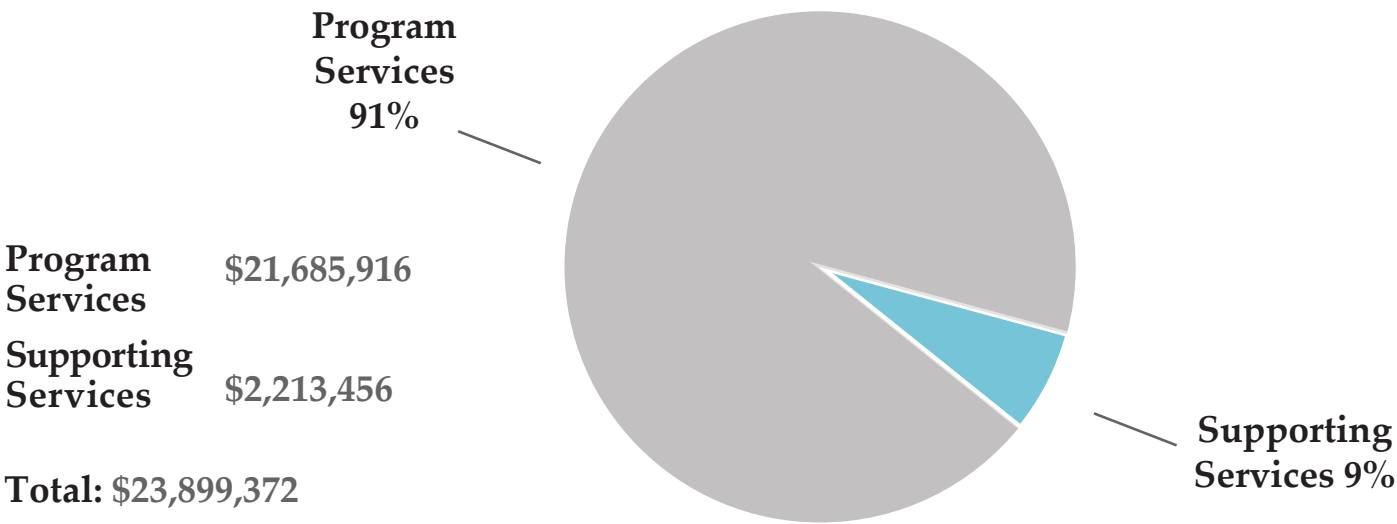


Statement of Financial Position



Where the Money Goes

Year ended 09/30/2019



Statement of Activities

Years ended September 30, 2019 and 2018
(In thousands)

	2019	2018
Support and Revenue		
Client Income	\$23,724	\$23,774
Grant Income	\$146	\$154
Released from Restriction	\$61	\$47
Total Support and Revenue	\$23,930	\$23,974
Expenses		
Program Services	\$21,686	\$22,464
Management and General	\$2,213	\$1,428
Fundraising	-	\$46
Total Expenses	\$23,899	\$23,939
Change in Net Assets from Operations	\$31	\$35
Investment Income, Net	\$112	\$90
Other non-operating Gains (Losses)	(117)	-
Other Income	\$31	-
Total Non-Operating Gains/Losses, Other Revenue	\$26	\$90
Change in Unrestricted Net Assets	\$57	\$126
Change in Temporarily Restricted Net Assets	\$24	\$71
Total Increase in Net Assets	\$33	\$197
Net Assets, Beginning of Year	\$7,821	\$7,625
Net Assets, End of Year	\$7,854	\$7,821

2019 Corporate Sponsors

- 101 Mobility
- Absolute Care, LC
- ACCESS Nursing Services
- Alert Response LLC
- All Staffing, Inc.
- AME Home Care
- Anthem Foundation
- Bank of America
- Canty's Helping Hands
- Chesapeake AED Services
- Cigna Healthcare
- Continuum Pediatric Nursing Services
- Corporate Synergies
- Elizabeth Cooney Care Network
- Enterprise Community Partners
- First Maryland Disability Trust
- Gilchrist Cares
- Guilford Retirement Services
- Heywood Oil and Gas, LLC.
- High Quality Care Inc.
- HomeCentris Healthcare
- Kelly Cove
- Kenedy Krieger Institute
- LifeBridge Health
- Maryland Department of Disabilities
- Maryland Technology Assistance Program
- MediRents & Sales, Inc.
- MOD Pizza
- Mom's Meals
- Mt. Washington Pediatric Hospital
- Numotion
- OpenArms Healthcare
- Professional Nursing Services
- Rudolph Office Supply
- STAAR Alert
- Sun Life Financial Services
- Therafit Rehab
- UBS Financial Services



2019 Donors

- Andrey Ostrovsky, M.D.
- Angela Green
- Carole Lowe-Nedab
- David Gresham
- Edward Feinberg, M.D.
- Elizabeth Weglein
- James Karpook
- Jeffrey Levy
- Jessica Coady
- Jill Fox Memorial Fund, Inc.
- John Gorman
- Joseph Green
- Martha Riva
- Melissa McCain
- Michael Gara
- Pamela Damsky
- Peggy Bailey
- Peter Johnsen
- Sally H. Hebner
- Steven & Chani Laufer
- Susan Magaw
- John and Susan Trumbule
- Thomas H. Hall
- Walter Barnett
- Zinoviy Fradlin

2020 Board of Directors

Thomas H. Hall, Board Chair
Marketing Consultant

Dianne Feeney, Board Vice Chair
Associate Director for Quality Initiatives
MD Health Services Cost Review Commission

Sally S. Hebner, CPA, Board Treasurer/Secretary
Chief Financial Officer
Enterprise Community Partners, Inc.

Peggy Bailey
Director, Health Integration Project
Center on Budget and Policy Priorities

Natacha Clavell
Senior Market Research Analyst
CareFirst BlueCross BlueShield

Carole Lowe-Nedab
Budget Manager
Prince George's County

James Karpook
Principal
The Chartis Group

H. Joseph Machicote
Sr. Vice President, Human Resources
Erickson Living

Andrey Ostrovsky, M.D.
President/CEO
Concerted Care Group

Naftali Rabinowitz
Consumer Representative
The Coordinating Center

Martha Riva, Esq.
Retired
Bon Secours Health System

Carole Taylor
Vice President, Technology
The Associated: Jewish Community Federation of Baltimore

Hillery Tsumba
Director, Strategy and External Affairs
Primary Care Coalition

Rick Wade
Communications Consultant
Rugby Hall Communications, LLC.

Elizabeth Weglein
CEO
Elizabeth Cooney Care Network

2020 Leadership Team

Teresa Titus-Howard
President/Chief Executive Officer

R. Colby Beach
Chief Operating Officer

Jennifer Sears
Chief Information Officer

Vacant
SVP, Finance and Administration /Chief Financial Officer

Renée Dain
SVP, Strategic Partnerships and External Affairs

Carol Duvall
SVP, Human Resources

Nancy Bond
SVP, Medical Legal Services

Sharyn King
SVP, Population Health Services

Karen Twigg
AVP, Community Health

Tricia Hogewood
Contracts and Compliance Manager